CUNA MUTUAL GROUP

CMFG Life Insurance Company

Retirement Plan Services
P.O. Box 2978 • 5910 Mineral Point Road
Madison, WI 53701-2978
Phone: 800.999.8786 • Fax: 608.236.7395
www.benefitsforyou.com

EMPLOYEE TERMINATION REQUEST
DEFINED BENEFIT RETIREMENT PLAN

TYPE OF BENEFIT REQUESTING

☐ **Actual** benefit calculation requested (check reason for leaving below):
- ☐ Termination ☐ Retirement ☐ Total and Permanent Disability
- ☐ Death (include copy of death certificate)
  - ☐ Use online Beneficiary Election for the death benefit. (If this box is not selected, please attach most recent beneficiary designation form.)

☐ **Estimated** benefit calculation requested (submit a separate form for each estimated date or estimated age)

EMPLOYER INFORMATION

Employer Name		
State	Employer Contract Number (8 digit)	Plan Number ☐ 001 ☐ 002 ☐ 022 ☐ Other _____

EMPLOYEE INFORMATION

Employee Name	Date of Birth / /	Social Security Number – –	Termination Date / /

Home Address Street City State Zip

Rehire Date (if applicable) / /	Marital Status ☐ Single ☐ Married	Spouse's Name	Spouse's Date of Birth / /	Phone Number (optional) ( )

HOURS OF SERVICE (for Vesting)

Enter the following dates. Then, determine if the employee worked more or less than 1,000 hours during these time frames:

			Under 500 hours	500-999 hours	1,000 hours or more
_____ Hire Date	Through	_____ Plan Anniversary Following Hire Date	☐	☐	☐
_____ Last Plan Anniversary Date	Through	_____ Termination Date	☐	☐	☐

These hours should include paid vacation and sick leave up to 501 hours. We will assume the employee worked 1,000 hours or more in each full plan year between the above dates unless otherwise noted on a separate sheet attached to this form.

SALARY

Enter the total includable compensation* earned during the highest consecutive 60 (or 36) months of service as defined in your plan.

	60 months	36 months	
Compensation from ___/___/___ through ___/___/___	(_____ months)	(_____ months)	$_____
Compensation for the entire plan year of _____	(12 months)	(12 months)	$_____
Compensation for the entire plan year of _____	(12 months)	(12 months)	$_____
Compensation for the entire plan year of _____	(12 months)		$_____
Compensation for the entire plan year of _____	(12 months)		$_____
Compensation from ___/___/___ through ___/___/___	(_____ months)	(_____ months)	$_____

*Please refer to the definition of compensation in your Plan document.

EMPLOYEE CONTRIBUTIONS (if applicable)

Enter contributions made by employee from last plan anniversary date to date of termination:

- Employee Contributions: $_____

PLAN ADMINISTRATOR SIGNATURE

I, as Plan Administrator, verify that the above information is correct.

Signature: **X**

Date

RETURN TO

ATTN Retirement Plan Services
CUNA Mutual Group
PO Box 2978
Madison WI 53701-2978